DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10114 (Rev. 01/04)

STATE OF WISCONSIN
WI Stat. s.49.45

MEDICAID DISABILITY REDETERMINATION REPORT

Use this report only for a redetermination for continued eligibility. When forwarding this information to the Agency of Health and Family Services, Disability Determination Bureau, please include the medical and social information reports on which the previous determination was based. Include updated medical releases authorizing release of medical records.

Under Wisconsin statute section 49.45 (4), personally identifiable information is only used for the direct administration of the Medicaid program.

Providing or applying for a Social Security Number (SSN) is voluntary; however, any person who wants Wisconsin Medicaid but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to s. 49.82(2) Wis. Stats. SSN information will be used for administration of the Medicaid program. A person's SSN permits a computer check of his or her information with government agencies such as the Internal Revenue Service (IRS), Social Security Administration (SSA) and the Department of Workforce Development (DWD). In addition, the Department of Health and Family Services (DHFS) will match the person's name and SSN with information provided by health insurance carriers to determine if he or she has other health insurance. The applicant's SSN will not be shared with the federal Bureau of Citizenship and Immigration Services (BCIS).

SECTION I - RECIPIENT INFORMATION

Name (Last, First, MI)	Social Security Number

Address (Street, City, State, Zip Code)	County

Sex	Age	Date of Birth	Name of Spouse	Telephone Number

SECTION II - DISABILITY INFORMATION (If additional space is needed go to Section VII)

Describe the disabling condition(s) for which you are receiving Medicaid Disability.

Has there been any change (better or worse) in your condition since you last reported to Medicaid?
☐ Yes ☐ No
If "Yes", describe change.

Do you have any new injuries or illnesses? ☐ Yes ☐ No If "Yes", describe new injury or illness.

Has your doctor told you that you are able to return to work? ☐ Yes ☐ No If "Yes", complete below. If "No", go to Section III.

List the name and address of the doctor(s) that told you that you could return to work.

Doctor's Name

Doctor's Address

What date did your doctor tell you that you could return to work? (MM/DD/YY)

Did your doctor restrict you to limited or part-time work? ☐ Yes ☐ No If "Yes", explain limitation.

SECTION III - MEDICAL RECORDS INFORMATION (If additional space is needed go to Section VII)

Have you applied for Social Security Disability Income (SSDI) or Supplement Security Income (SSI) benefits? Yes ☐ No ☐ If "Yes", complete section below.

What is the date of your last application?

What is the address of the Social Security office where you last applied?

What is the status of your claim? ☐ Allowed ☐ Denied ☐ Pending

If you are receiving SSDI or SSI benefits, have you had a review? ☐ Yes ☐ No If "Yes", what is the date of your last review?

Have you seen a doctor for your injury or illness? ☐ Yes ☐ No. If "Yes", complete below.

List the name, address and telephone number of the doctor(s) who has the latest medical records about your disability.

Doctor's Name	Telephone Number

Doctor's Address

How often do you see this doctor?	Date you were last seen by this doctor.

Describe the reason you were / are being seen by this doctor.

Describe the type of treatment, surgery or medications received.

If you have seen more than one doctor, list the additional information here.

Doctor's Name	Telephone Number

Doctor's Address

How often do you see this doctor?	Date your were last seen by this doctor.

Describe the reason you were / are being seen by this doctor.

Describe the type of treatment, surgery or medications received.

Have you been hospitalized or treated at a clinic for your disability in the last 12-months?
☐ Yes ☐ No If "Yes", complete below. If "No", go to Section V.

Name of Hospital or Clinic	Patient Number

Address of Hospital or Clinic

Were you an inpatient (stayed overnight at least one night)? ☐ Yes ☐ No If "Yes", complete below.

What was the date that you were admitted?	What is the date that you were discharged?

Were you an outpatient? ☐ Yes ☐ No If "Yes", list the dates that you were seen.

Describe the reason for your hospitalization or clinic visits.

Describe the type of treatment, surgery or medications that you received.

Have you had any of the following tests in the last 12-months?

Test		Date of test	Facility where test was done
Electrocardiogram (EKG)	☐ Yes ☐ No		
Chest X-Ray	☐ Yes ☐ No		
Other X-Ray (describe below)	☐ Yes ☐ No		
Breathing Test	☐ Yes ☐ No		
Blood Test (describe below)	☐ Yes ☐ No		
Other Test (describe below)	☐ Yes ☐ No		

Describe the types of test you received.

Describe the daily activities you do that are listed below. Indicate which activities you do and how often they are done.

Household Maintenance (including cooking, cleaning, shopping and odd jobs around your house as well as including similar activities)

Recreational Activities and Hobbies (such as hunting, fishing, bowling, hiking, musical activities)

Social Contact (such as visits with friends, relatives, neighbors)

Other Activities (such as drive car or motorcycle, ride bus)

Has your doctor limited any of the activities that you listed above? ☐ Yes ☐ No. If Yes", describe the limitations.

Have you been seen by other agencies (Veteran's Administration, Worker's Compensation, Vocational Rehabilitation or Social Services, etc) for your disabling condition? ☐ Yes ☐ No If "Yes", complete the following:

Name of Agency

Claim Number	Dates of Visits

Describe services, treatment, surgery or medication received.

SECTION V - WORK HISTORY

Are you currently working? ☐ Yes ☐ No If "Yes", complete below. If "No", go to Section VI.

Name of Employer

Address of Employer

Job Title	Date of Hire
Hours work per week	Rate of Pay $

SECTION VI - EDUCATION INFORMATION

Have you attended (trade, vocational or academic) school or had any other type of training since you began receiving Medicaid? ☐ Yes ☐ No If "Yes", complete below. If "No", go to Section VII.

Describe type of training

Are you attending school? ☐ Yes ☐ No	What grade are you currently in?

Name of School

Address of School

SECTION VII – ADDITIONAL INFORMATION

Use this section for additional information that you think will be helpful in making a decision in your Medicaid Disability redetermination, or to answer any previous question where additional space was needed. List information such as other illnesses or injuries not listed in previous sections, other doctors that you have seen or hospitalizations that you have not previously described. Please refer to the previous section numbers when describing additional information.

SECTION VIII SIGNATURE OF RECIPIENT / AUTHORIZED REPRESENTATIVE

I understand the questions and statements on this report. I understand the penalties for giving false information or breaking rules. I certify, under penalty of false swearing, that all my answers are complete to the best of my knowledge. I understand that the agency may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits. (The recipient's signature must be witnessed by two people if signed with an "X".)

SIGNATURE - Name of recipient or authorized representative	Date Signed
SIGNATURE – Witness	Date Signed
SIGNATURE – Witness	Date Signed

SECTION VIII – AUTHORIZATION OF REPRESENTATION

This section must be completed by the person who completed this Medicaid Disability Redetermination report on behalf of a recipient. Documentation must be provided to the recipient's local county/tribal social or human or services agency.

Did you complete a Medicaid Disability Redetermination report on behalf of another person and are you that person's court appointed guardian, conservator or have durable power of attorney for health care for that person?

☐ Yes ☐ No

If you answered "Yes", stop here. You must submit, to the local county/tribal social or human services agency, the legal documentation authorizing you to be that person's appointed guardian or durable power of attorney for finances.

Are you an authorized representative completing the Medicaid Disability Redetermination report for another person?

☐ Yes ☐ No

If you are an Authorized Representative, then:
1. You and the recipient must complete the information below.
2. Both you and the recipient must sign the Signature Section of this report.
3. Both you and the recipient must sign this report in order for you to be an authorized representative.

Name - Authorized Representative (Last, First, MI)	Telephone Number ( )
Address (Street, City, State, Zip Code)	E-mail Address (Optional)

I authorize _____(name of representative) to represent me in my Medicaid Disability Redetermination report to be filed with the county/tribal social or human services agency administering the program and in the reviews of my eligibility. I also authorize my representative to provide information and documents which may be necessary to establish my disability redetermination. I will provide information to my representative that will be true and correct to the best of my knowledge. My representative and I understand that penalties for providing fraudulent information could be a fine of up to $25,000, imprisoned up to seven years and six months, or both and suspended from Wisconsin Medicaid (NOTE: Someone other than your representative must witness your signature. Two witness signatures are required if you sign with an "X".)

SIGNATURE – Recipient / Representative / Guardian / Health Care Power of Attorney / Conservator	Date Signed
SIGNATURE – Witness	Date Signed
SIGNATURE – Witness	Date Signed

As an authorized representative I understand that I am representing the above named recipient for Medicaid Disability redetermination and that information provided is true and correct to the best of my knowledge.

SIGNATURE – Authorized Representative	Date Signed

SECTION VIII - OFFICE USE ONLY

INFORMATION TO BE COMPLETED BY THE INTERVIEWER. THE INTERVIEWER SHOULD BE A SUPPORTIVE SERVICES PLANNER OR SOCIAL WORKER.

Does the recipient need assistance processing this claim? ☐ Yes ☐ No

If yes, list name, address, and telephone number of the person who will assist the recipient.

Name (Last, First, MI)	Relationship
Address (Street, City, State, Zip Code)	Telephone Number

Can the recipient speak English? ☐ Yes ☐ No	If recipient cannot speak English, what language can the reccipient speak?
Can the recipient read English? ☐ Yes ☐ No	Can the recipient write in English (Other than his/her name)? ☐ Yes ☐ No

If the recipient cannot speak English list the name of someone that may be contacted who speaks English and will give the recipient messages.

Name (Last, First, MI)	Relationship to Recipient
Address (Street, City, State, Zip Code)	Daytime Telephone Number

Describe the recipient fully (e.g. general build, height, weight, behavior, grooming and any problems with the ability to read, write, answer, hear, sit, understand, use hands, breathe, see or walk.)

Print Name - Interviewer	Title of Interviewer

SIGNATURE - Interviewer	Date Signed
Office Address (Street, City, State, Zip Code)	Telephone Number
Email Address	Fax Number